FINAL REPORT OF RECOMMENDATIONS AND FINDINGS

By the Licensed Mental Health Practitioners Technical Review Committee
for the Review of the Application for Change in Scope of Practice in Nebraska
by the Licensed Mental Health Practitioners of Nebraska

To the Nebraska State Board of Health, the
Director of the Department of Health and Human Services Regulation
and Licensure, and the Legislature

Final Recommendations were Formulated
on
September 23, 2005

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INTRODUCTION

The Credentialing Review Program is a review process advisory to the Legislature, designed to assess the need for state regulation of health professionals. The credentialing review statute requires that review bodies assess the need for credentialing proposals by examining whether such proposals are in the public interest.

The law directs those health occupations and professions seeking credentialing or a change in scope of practice to submit an application for review to the Health and Human Services Department of Regulation and Licensure. The Director of this agency will then appoint an appropriate technical review committee to review the application and make recommendations regarding whether or not the application in question should be approved. These recommendations are made in accordance with four statutory criteria contained in Section 71-6221 of the Nebraska Revised Statutes. These criteria focus the attention of committee members on the public health, safety, and welfare.

The recommendations of technical review committees take the form of written reports that are submitted to the State Board of Health and the Director of the Agency along with any other materials requested by these review bodies. These two review bodies formulate their own independent reports on credentialing proposals. All reports that are generated by the program are submitted to the Legislature to assist state senators in their review of proposed legislation pertinent to the credentialing of health care professions.

MEMBERS OF THE LICENSED MENTAL HEALTH PRACTITIONERS TECHNICAL REVIEW COMMITTEE

Leslie Spry, M.D. (Chairperson)
(Lincoln)

Kevin Kaminski, L.M.H.P.
(Omaha)

James Madison, Ph.D.
(Omaha)

Todd Stull, M.D.
(Omaha)

Sheila Minnick, R.N.
(Hastings)

Lisa Runco
(Omaha)

Cindy Mayer
(Kearney)

EXECUTIVE SUMMARY OF THE PROPOSAL AND RECOMMENDATIONS

SUMMARY OF THE APPLICANTS' PROPOSAL

The proposal makes the following changes to the LMHP statute:

1. Current statutory provisions in Section 71-1,307 Revised Statutes of Nebraska pertinent to diagnosis and treatment of major mental disorders, including the requirement that an LMHP must consult with either a qualified physician or a psychologist before being allowed to diagnose and treat a patient with a major mental disorder are deleted. **(The Applicants' Proposal, Page 7, Question 4)**

2. The following proposed language is inserted into **Section 71-1,307** in place of the original language:

   "Mental health practice shall include assessment of organic mental or emotional disorders and diagnosis of major mental disorders for the purpose of treatment, referral, or consultation."

   The statute would continue to include the following original language:

   "Mental health practice shall not include the practice of psychology or medicine, prescribing drugs or electroconvulsive therapy, treating physical disease, injury, or deformity, or measuring personality or intelligence for the purpose of diagnosis or treatment planning." **(The Applicants' Proposal, Page 7, Question 4)**

3. Treatment of major mental disorders by LMHPs would include treating the "organic concomitants" of such disorders. **(The Applicants' Proposal, Page 8, Question 5)**

4. All licensed LMHPs will be required to obtain at least 6 hours of continuing education requirements related to the diagnosis of major mental disorders during the 24-month licensure renewal period. **(The Applicants' Proposal, Page 8, Question 5)**

5. All LMHP practitioners would be included under the proposal once they become fully licensed. LMHPs can, if they so desire, choose to maintain a supervisory or consultative relationship with other mental health practitioners. **(The Applicants' Proposal, Page 17, Question 27)**

The First Amended Version of the LMHP Proposal

During the review process the proposal was amended as follows. (A subsequent amended version is contained on pages 7 and 8 of this report.)

1. **Rename Provisional Mental Health Practitioner as follows:**

   "Certified Mental Health Practitioner" (CMHP)
   (a) All supervisory stipulations would remain unchanged
   (b) Graduates from nationally accredited programs would also be denoted by the following titles: (CSW, CMFT and CPC)
   (c) Graduates from non-nationally accredited programs would be given the title of CMHP

2. **CMHP provisions would be as follows:**

   Those who graduate from a nationally accredited program (such as CACREP, COAMFTE or CSW) would complete, within a minimum of 2 years and a maximum of 5 years, 3000 hours of documented supervised experience. Upon completion, candidates would then be eligible to apply for full and independent licensure as an LPC, LMFT, LCSW, and/or LMHP.

   Those who graduate from a program that is not nationally accredited by CACREP, COAMFTE or CSWE would need to practice a minimum of 7 years, and complete 6000 hours of documented supervised experience. During this time, they would need to meet the regulations and legislative guidelines for the current PLMHP designation. They would then be eligible for full licensure as an LMHP or as an LCSW, LPC or LMFT if they meet the clinical membership guidelines of the respective national association.

3. **Grand-parenting provisions would be as follows:**

   Those who graduate from a nationally accredited program on or before July 1, 2004, and have met the supervision requirements, would be eligible for full licensure on July 1, 2006.

   Those who graduated from non-nationally accredited programs on or before July 1, 1999, and have a minimum of 7 years supervised experience would be eligible for independent practice on July 1, 2006. They would be eligible for full licensing status as an LMHP, or as an LCSW, LPC or LMFT if they meet the clinical membership guidelines from the national association.

4. **Code of ethics provisions would be as follows:**

   All non-nationally accredited program graduates, upon licensure renewal, would need to document which one of the following codes of ethics (ACA, AAMFT, NASW, APA or AMHCA) they intend to adhere to in order to comply with this requirement.

5. **Continuing education provisions would be as follows:**

   The requirement would be that 6 of the 32 hours be specific to diagnostics, taking into account that 2 hours are already designated for ethics training, leaving 30 hours. **(Submitted by the applicant group representative during the fifth meeting of the committee, March 18, 2005.)**

The Final Amended Version of the Proposal

Later in the review process on LMHP issues the proposal was amended again, and the text of the amended version of the proposal is as follows:

- Applicants with the required education shall initially be licensed as a Provisional Licensed Mental Health Practitioner (PLMHP). Provisional Licensed Mental Health Practitioners shall complete 3,000 hours of documented supervised experience within a minimum of two years and a maximum of five years after their initial licensure to obtain the status of Licensed Mental Health Practitioner (LMHP). Licensed Mental Health Practitioners may additionally apply to be Licensed Marriage and Family Therapists, Licensed Professional Counselors, or Licensed Certified Social Workers, which will operate the same as the current statute.

- Applicants who graduate from nationally accredited professional programs and wish to obtain the status of a Licensed Independent Mental Health Practitioner (LIMHP) must complete 50% of their client contact hours, within the 3,000 hours of supervised experience, with clients diagnosed under the major mental disease category. Supervision must be provided by a qualified physician, a licensed psychologist, or a licensed independent mental health practitioner.

- Applicants who have completed the required experience and client contact hours can be licensed as a LIMHP in one of the following categories: Licensed Independent Marriage and Family Therapist, Licensed Independent Clinical Social Worker, or Licensed Independent Professional Counselor.

- Applicants who graduate from a non-nationally accredited professional program can apply for licensure as a Licensed Independent Mental Health Practitioner upon completion of 7,000 hours (including the 3,000 hours of supervision as specified above) of supervised practice over a minimum of ten years, including a minimum of 50% of client contact hours with clients diagnosed under the major mental disease category. Supervision must be provided by a qualified physician, a licensed psychologist, or a licensed independent mental health practitioner.

- Licensed Mental Health Practitioners who are licensed on the effective date of the new statute, and who wish to become a Licensed Independent Mental Health Practitioner and have graduated from a nationally-accredited professional program, shall document for the licensure board a minimum of two years and 3,000 hours of supervised experience which shall include a minimum of 50% of client contact hours with clients diagnosed under the major mental disease category.

- Licensed Mental Health Practitioners who are licensed on the effective date of the new statute, and who wish to become Licensed Independent Mental Health Practitioners, and have graduated from non-nationally accredited professional programs, shall document for the licensure board a minimum of ten years and 7,000 hours of supervised/consultation experience which shall included a minimum of 50% of client contact hours with clients diagnosed under the major mental disease category.

- The licensure board shall accept reasonable documentation of the required experience of contact hours. Documentation may include sworn statements from employers and supervisors, as well as the applicant, but shall not in any case require the applicant to produce individual client case records.

Overview of Final Version of the LMHP Proposal

- The PLMHP statute criterion remains the same and will include additional supervision documentation for those who choose to move to the Licensed Independent Mental Health Practitioner level. "… must complete 50% of their client contact hours, within the 3,000 hours of supervised experience, with clients diagnosed under the major mental disease category."

- The LMHP statute criterion remains the same and will include additional supervision documentation for those who choose to move to the Licensed Independent Mental Health Practitioner level.

- The Licensed Independent Mental Health Practitioner level of licensure is new and is defined within this proposal.

- Supervision and consultation criteria are currently defined in the regulations.

- It is suggested that the Mental Health Licensing Board consider including that 6 of the 32 continuing education requirements be related to MMD diagnoses for those renewing the Licensed Independent Mental Health Practitioner license.

SUMMARY OF COMMITTEE RECOMMENDATIONS

The committee members recommended approval of the final amended version of the applicants' proposal, the text of which is contained on pages seven and eight of this report.

The committee members recommended that the Agency and all other interested parties to the proposal network with Nebraska Medicaid officials regarding the need for modifications in Medicaid rules and regulations pertinent to LMHPs so that these practitioners are no longer required to consult with a specific psychologist or psychiatrist before they can treat their patients. The committee members hoped that this would lessen the restrictiveness of the current regulatory process for LMHPs, and that this would in turn improve access to care.

The committee members also recommended that the Agency, the Nebraska Medical Association, and the Nebraska Psychological Association admonish Nebraska psychiatrists and psychologists to give timely responses to those LMHPs who contact them regarding patients whose preliminary diagnoses indicate that a consultation with either a psychologist or a psychiatrist is needed.

FULL ACCOUNT OF COMMITTEE RECOMMENDATIONS

All text in this section of the report comes from the proceedings of the fifth meeting of the LMHP technical review committee.

The committee members discussed the latest modifications to the proposal submitted by the applicant group at the beginning of this meeting **(these modifications are described on pages five and six of this report).** Mr. Kaminski commented that the proposed modifications represent two different paths to get to the same end, which is independent diagnosis and treatment of major mental disorders for all LMHPs who are qualified. Mr. Kaminski commented that the purpose of the changes is to bring the so-called "like groups" up to the standard of the rest of LMHPs pertinent to diagnosis and treatment of major mental disorders.

Dr. Madison commented that renaming the provisionally licensed category could create an issue with insurance companies since they are used to reimbursing only for licensed practitioners, not for certified providers. Mr. Kaminski responded that there are insurance providers for whom this will not be a problem, including Blue Cross and Blue Shield. He added that in other states that use this same terminology there has not been a problem with reimbursement. The "like groups" would only have title protection until they meet the standards for licensure.

Dr. Madison commented that the grand-parenting provision may be somewhat premature due to the fact that the exact nature of the standards that must be satisfied for such a provision have not yet been firmly set in place, as witnessed by the ongoing modifications to the proposal by the applicant group.

Dr. Madison then commented on that aspect of the amended proposal pertaining to the requirement that the "like groups" must join a national association in order to be held to a code of ethics. Dr. Madison asked whether the state may legally require a practitioner to join a private association as a precondition for meeting a licensure standard. Mr. Kaminski responded that this is already being done vis-à-vis the three major LMHP groups now, and that there is no reason why it could not also be done for other LMHP practitioners. Dr. Madison and Dr. Spry commented that it would be better not to take a chance on this being unconstitutional, and simply state that all practitioners must satisfy one of the specified codes of ethics and leave it to the individual practitioner how he or she would satisfy the requirement. Mr. Kaminski indicated his agreement with their comments, and that the proposal would be changed to reflect this.

Dr. Madison then commented on the 6000 hours being proposed for the "like groups." Dr. Madison stated that there is nothing in this proposed requirement that clarifies that a practitioner who completes it has spent a specified amount of documented time dealing with major mental disorders. Dr. Stull indicated that this was also a concern of his as he read the proposed changes to the proposal. He commented that it is unclear how these 6000 hours would bring these practitioners up to standard given that they lack adequate education or training in diagnosis and treatment of major mental illnesses in the first place. He added that it is not clear whether any of these hours would be dedicated to the classroom instruction that is so necessary in order to understand the clinical aspects of the proposed training.

Dr. Stull then commented that current trends in the regulation of health care professionals emphasizes testing and re-testing pertinent to advanced practice knowledge and skills, and that this does not seem to be a part of any version of the LMHP proposal that he had seen to that point in time. Mr. Kaminski responded that any aspect of the proposed new training could be audited to ensure compliance with an established standard. He added that continuing education could be focused on maintaining certain skill sets, but that re-testing is out of the question because only a

specialty certification process could do that, and what is being proposed is not a specialty certification.

Dr. Spry asked the applicant representative whether or not he would ever as an independent practitioner diagnose or treat a patient with an MMD without consulting with either a psychologist or a psychiatrist at some point in the treatment process. Mr. Kaminski responded that he would consult, and that his code of ethics, which has the force of law behind it, requires him to do so. Mr. Kaminski commented that a given practitioner could chose to practice in a manner not consistent with ethical guidelines, but added that this is no more likely than would be the case with any other type of licensed health care provider. He added that it is reasonable to trust the professionalism of LMHPs just as it is to trust the professionalism of other types of licensed health care providers. Dr. Spry commented that there is a need for some kind of consultation requirement somewhere in the statute.

Before the committee members took action on the four criteria, they acted on a motion by Mr. Kaminski and a second by Cindy Mayer that the amendment to the proposal submitted by the applicant group at the beginning of this meeting be adopted by the committee members as a component of the proposal. Voting aye were Stull, Runco, Madison, Kaminski, and Mayer. Dr. Spry abstained from voting. There were no nay votes. The motion passed.

The version acted upon at this point in the review process was as follows:

1. **Rename Provisional Mental Health Practitioner as follows**:

   "Certified Mental Health Practitioner" (CMHP)
   (a) All supervisory stipulations would remain unchanged
   (b) Graduates from nationally accredited programs would also be denoted by the following titles: (CSW, CMFT and CPC)
   (c) Graduates from non-nationally accredited programs would be given the title of CMHP

2. **CMHP provisions would be as follows**:

   a. Those who graduate from a nationally accredited program (such as CACREP, COAMFTE or CSW) would complete, within a minimum of 2 years and a maximum of 5 years, 3000 hours of documented supervised experience. Upon completion, candidates would then be eligible to apply for full and independent licensure as an LPC, LMFT, LCSW, and/or LMHP.

   b. Those who graduate from a program that is not nationally accredited by CACREP, COAMFTE or CSWE would need to practice a minimum of 7 years, and complete 6000 hours of documented supervised experience. During this time, they would need to meet the regulations and legislative guidelines for the current PLMHP designation. They would then be eligible for full licensure as an LMHP, or as an LCSW, LPC or LMFT if they meet the clinical membership guidelines of the respective national association.

3. **Grand-parenting provisions would be as follows**:

   a. Those who graduate from a nationally accredited program on or before July 1, 2004 and have met the supervision requirements would be eligible for full licensure on July 1, 2006.

   b. Those who graduated from non-nationally accredited programs on or before July 1, 1999 and have a minimum of 7 years supervised experience would be eligible for independent practice on July 1, 2006. They would be eligible for full licensing status as an LMHP, or as

an LCSW, LPC or LMFT if they meet the clinical membership guidelines from the national association.

4. **Code of ethics provisions would be as follows**:

   All non-nationally accredited program graduates, upon licensure renewal, would need to document which one of the following codes of ethics (ACA, AAMFT, NASW, APA or AMHCA) they intend to adhere to in order to comply with this requirement.

5. **Continuing education provisions would be as follows**:

   The requirement would be that 6 of the 32 hours be specific to diagnostics, taking into account that 2 hours are already designated for ethics training, leaving 30 hours.

The committee members then applied the four criteria to this version of the proposal as follows:

The committee members discussed and acted upon the first criterion.

Criterion one states:

The present scope of practice or limitations on the scope of practice creates a situation of harm or danger to the health, safety, or welfare of the public, and the potential for the harm is easily recognizable and not remote or dependent upon tenuous argument.

Mr. Kaminski moved and Cindy Mayer seconded that the proposal satisfies the first criterion. Voting aye were Mayer, Stull, Runco, and Kaminski. Voting nay was Madison. The motion passed. Dr. Spry abstained from voting.

The committee members then discussed and acted upon the second criterion.

Criterion two states:

The proposed change in scope of practice does not create a significant new danger to the health, safety or welfare of the public.

Mr. Kaminski moved and Lisa Runco seconded that the proposal satisfies the second criterion. Voting aye was Kaminski. Voting nay were Madison, Stull, Runco, and Mayer. The motion failed. Dr. Spry abstained from voting. By this action the committee members decided not to recommend approval of the proposal.

Lisa Runco commented after the voting on this criterion that the applicants have not clarified how education and training specific to the diagnosis and treatment of major mental disorders for LMHPs would be documented, and that this was a major concern of hers in the voting on this criterion. Cindy Mayer commented that the proposal needs to specify how much of the additional hours of training for non-nationally accredited practitioners would be dedicated to the diagnosis and treatment of major mental disorders. Cindy Mayer also commented that documentation of experience acquired by these practitioners in their education and training pertinent to major mental disorders is essential, and that the proposal does not provide for this.

The committee members then discussed and acted upon the third criterion.

Criterion three states:

Enactment of the proposed change in scope of practice would benefit the health, safety, or welfare of the public.

Mr. Kaminski moved and Lisa Runco seconded that the proposal satisfies the third criterion. Voting aye were Mayer, Madison, Stull, Kaminski, and Runco. There were no nay votes. The motion passed. Dr. Spry abstained from voting.

Cindy Mayer commented after the voting on this criterion that there is a need to increase access to mental health care in rural areas, and that the proposal does offer hope of improvement in access to care in these areas.

The committee members then discussed and acted upon the fourth criterion.

Criterion four states:

The public cannot be effectively protected by other means in a more cost-effective manner.

Mr. Kaminski moved and Cindy Mayer seconded that the proposal satisfies the fourth criterion. Voting aye were Mayer, Stull, Runco, and Kaminski. Voting nay was Madison. The motion passed. Dr. Spry abstained from voting.

Dr. Madison commented after the voting on this criterion that there are better ways of addressing the concerns raised by the applicant group, and that the committee members had reviewed better options to the proposal during the course of the review.

By these four votes on the criteria, the committee members recommended against approval of this version of the proposal.

(Please turn to page 14 in this report for a discussion on subsequent committee deliberations on the four criteria that occurred at a special meeting of the committee.)

Ancillary Recommendations and Final Discussion on the Issues of the Review

The committee members recommended that the Agency and all other interested parties to the proposal network with Nebraska Medicaid officials regarding the need for modifications in Medicaid rules and regulations pertinent to LMHPs so that these practitioners are no longer required to consult with a specific psychologist or psychiatrist before they can treat their patients. The committee members hoped that this would lessen the restrictiveness of the current regulatory process for LMHPs, and that this would in turn improve access to care. The committee members also recommended that the Agency, the Nebraska Medical Association, and the Nebraska Psychological Association admonish Nebraska psychiatrists and psychologists to give timely responses to those LMHPs who contact them regarding patients whose preliminary diagnoses indicate that a consultation with either a psychologist or a psychiatrist is needed.

Recommendations Formulated During a Special Meeting of the Technical Committee

At the request of the Director of the Department, a special meeting of the committee was held on September 23, 2005 to review a version of the proposal that was developed on the issues since they last met. The text of this final version of the proposal is as follows:

- Applicants with the required education shall initially be licensed as a Provisional Licensed Mental Health Practitioner (PLMHP). Provisional Licensed Mental Health Practitioners shall complete 3,000 hours of documented supervised experience, within a minimum of two years and a maximum of five years after their initial licensure, to obtain the status of Licensed Mental Health Practitioner (LMHP). Licensed Mental Health Practitioners may additionally apply to be Licensed Marriage and Family Therapists, Licensed Professional Counselors, or Licensed Certified Social Workers, which will operate the same as the current statute.

- Applicants who graduate from nationally accredited professional programs and wish to obtain the status of a Licensed Independent Mental Health Practitioner (LIMHP) must complete 50% of their client contact hours, within the 3,000 hours of supervised experience, with clients diagnosed under the major mental disease category. Supervision must be provided by a qualified physician, a licensed psychologist, or a licensed independent mental health practitioner.

- Applicants who have completed the required experience and client contact hours can be licensed as a LIMHP in one of the following categories: Licensed Independent Marriage and Family Therapist, Licensed Independent Clinical Social Worker, or Licensed Independent Professional Counselor.

- Applicants who graduate from a non-nationally accredited professional program can apply for licensure as a Licensed Independent Mental Health Practitioner upon completion of 7,000 hours (including the 3,000 hours of supervision as specified above) of supervised practice over a minimum of ten years, including a minimum of 50% of client contact hours with clients diagnosed under the major mental disease category. Supervision must be provided by a qualified physician, a licensed psychologist, or a licensed independent mental health practitioner.

- Licensed Mental Health Practitioners who are licensed on the effective date of the new statute, and who wish to become a Licensed Independent Mental Health Practitioner and have graduated from a nationally-accredited professional program, shall document for the licensure board a minimum of two years and 3,000 hours of supervised experience which shall include a minimum of 50% of client contact hours with clients diagnosed under the major mental disease category.

- Licensed Mental Health Practitioners who are licensed on the effective date of the new statute, and who wish to become Licensed Independent Mental Health Practitioners, and have graduated from non-nationally accredited professional programs, shall document for the licensure board a minimum of ten years and 7,000 hours of supervised/consultation experience which shall included a minimum of 50% of client contact hours with clients diagnosed under the major mental disease category.

- The licensure board shall accept reasonable documentation of the required experience of contact hours. Documentation may include sworn statements from employers and supervisors, as well as the applicant, but shall not in any case require the applicant to produce individual

client case records.

Overview of the Final LMHP Proposal

- The PLMHP statute criterion remains the same and will include additional supervision documentation for those who choose to move to the Licensed Independent Mental Health Practitioner level. "… must complete 50% of their client contact hours, within the 3,000 hours of supervised experience, with clients diagnosed under the major mental disease category."

- The LMHP statute criterion remains the same and will include additional supervision documentation for those who choose to move to the Licensed Independent Mental Health Practitioner level.

- The Licensed Independent Mental Health Practitioner level of licensure is new and is defined within this proposal.

- Supervision and consultation criteria are currently defined in the regulations.

- It is suggested that the Mental Health Licensing Board consider including that 6 of the 32 continuing education requirements be related to MMD diagnoses for those renewing the Licensed Independent Mental Health Practitioner license.

During the special meeting, the committee members heard testimony on the final version of the proposal from James Cole, Ph.D., a clinical psychologist, and from Louise Jeffrey, Ph.D., both of whom presented testimony on behalf of the Nebraska Psychological Association. Dr. Cole informed the committee members that the evaluation and treatment of major mental disorders involves more than making accurate diagnoses or developing treatment strategies. It involves the necessary skills, knowledge, and flexibility necessary for an independent practitioner to develop treatment plans that address the comprehensive, diverse, and individualized intervention needs of patients who have severe mental disorders. He went on to state that the risks for these patients is greater than for those with other kinds of disorders, and that these risks can involve threats to the lives of these patients or to the lives of others.

Dr. Cole applauded the improvements made by the applicants to their proposal since the technical committee last met, but indicated that there still needs to be additional modifications to the proposal. He stated that the first change that is needed is to include a minimum three-hour graduate level course in psychopathology that includes empirically grounded analysis and diagnosis of major mental disorders. Additionally, all LMHPs who want to do the new scope of practice should be able to document that they have completed a minimum of six hours of graduate level course work in evidence-based theory and interventions. The second change that is needed is to more specifically define the exact nature of the supervised clinical experience so as to prevent a situation wherein a supervisor simply "signs off" on the supervised person's activities without actually overseeing their work. The third change that is needed is to ensure that any continuing education required meets the standards of a nationally accredited professional institution. The fourth change that is needed is to make membership in one of the three professional associations mandatory in order to facilitate the professional development of the practitioners who are in need of upgrading their diagnostic and therapeutic skills.

During discussion that occurred after the presentation of testimony, Kevin Kaminski commented that the revised proposal already requires that those who are graduates of non-nationally accredited programs satisfy all of the standards necessary, including didactic standards, to qualify to be independent practitioners. Pertinent to the idea of mandating membership in at least one of the three mental health associations referred to by Dr. Cole, Mr. Kaminski commented that there are legal and constitutional barriers to this idea. Dr. Cole commented that in whatever manner this issue is approached it must be done so that there is one standard, not three separate standards. Mr. Kaminski responded that the three associations are very close on their definitions of ethical standards and that most of the differences pertain to how provisions are worded rather than in the meaning of the provisions per se. He went on to state that each professional would be held to a code of ethics regardless of where they come from professionally and educationally speaking, and that those from the non-accredited programs would be held to the American Professional Counseling Association's code of ethics.

Dr. Madison commented that the final version of the proposal represents a great improvement over the previous versions, but stated that there are still issues regarding the non-accredited practitioners. Dr. Madison stated that those practitioners should be required to get additional didactic education before being allowed to diagnose and treat major mental disorders independently. He commented that the final version of the proposal focuses primarily on providing them with additional clinical training rather than with additional didactic education. Dr. Spry commented that the required additional 7000 hours over a period of ten years should be sufficient to bring the non-accredited practitioners up to standard. Dr. Madison responded that the problem with the 7000-hour concept is that it focuses almost exclusively on training, and places insufficient emphasis on education.

The committee members then took action on the final version of the proposal by applying the four statutory criteria as follows:

Criterion one states:

The present scope of practice or limitations on the scope of practice creates a situation of harm or danger to the health, safety, or welfare of the public, and the potential for the harm is easily recognizable and not remote or dependent upon tenuous argument.

Kevin Kaminski moved and Lisa Runco seconded that the proposal satisfies the first criterion. Voting aye were Kaminski, Madison, Runco, and Stull. Dr. Spry abstained from voting. The motion passed.

The committee members then commented on their votes. Lisa Runco observed that mental health services in our state are in "dire straits" and that access to care issues are a big part of the problem. Mr. Kaminski commented that access to care is a major problem in mental health, and that current statutory restrictions on LMHPs only accentuates this problem. Dr. Madison commented that access to care in a timely manner is a problem under the current situation. Dr. Stull observed that of the fifty states, Nebraska is forty-ninth in providing funding for mental health services, and agreed that there are problems with access to these services in our state. Dr. Spry commented that it is important that the public be advised of the need to improve access to mental health services, and that this review could play a role in increasing public awareness of this problem.

Criterion two states:

The proposed change in scope of practice does not create a significant new danger to the health, safety or welfare of the public.

Kevin Kaminski moved and Lisa Runco seconded that the proposal satisfies the second criterion. Voting aye were Kaminski, Runco, and Stull. Dr. Madison voted against the motion. Dr. Spry abstained from voting. The motion passed.

The committee members then commented on their votes. Dr. Madison stated that the final version of the proposal is a greatly improved version of it, but that it still does not go far enough toward addressing the educational deficiencies of the non-accredited practitioners. Dr. Stull commented that the ideas recommended by Dr. Cole would greatly improve the proposal, which currently lacks sufficient emphasis on didactics. Mr. Kaminski commented that potential for harm stems from the current access to care problems, not the proposal. Dr. Spry stated that the ten-year 7000-hour clinical training program should be sufficient to bring these providers up to standard. Lisa Runco cautioned that it is important that the new proposed training be done in a manner consistent with a common standard that is defined by a regulatory body like a board of examiners.

Criterion three states:

Enactment of the proposed change in scope of practice would benefit the health, safety, or welfare of the public.

Kevin Kaminski moved and Todd Stull seconded that the proposal satisfies the third criterion. Voting aye were Kaminski, Madison, Runco, and Stull. Dr. Spry abstained from voting. The motion passed.

The committee members then commented on their votes. Mr. Kaminski stated that the benefit of the proposal would be improved access to mental health care. Dr. Spry stated that the proposal would also focus attention of policy makers on the need for improved access to mental health care.

Criterion four states:

The public cannot be effectively protected by other means in a more cost-effective manner.

Kevin Kaminski moved and Lisa Runco seconded that the proposal satisfies the fourth criterion. Voting aye were Kaminski, Runco, and Spry. Voting nay were Madison and Stull. There were no abstentions. The motion passed.

The committee members then commented on their votes. Dr. Madison restated his concern about the need for more education for the non-accredited practitioners before they would be allowed to diagnose and treat major mental disorders independently. Dr. Spry commented that he understands the concerns of those persons who cite the need for more education, but added that he is confident that the 7000-hour clinical training program would be sufficient preparation for independent practice pertinent to diagnosis and treatment of major mental disorders.

By these four votes the technical committee members recommended approval of the final amended version of the applicant groups' proposal.

COMMITTEE DISCUSSION ON ISSUES OF THE REVIEW
(Prior to the September 23, 2005 Special Meeting)

1. Do the restrictions on current LMHP practice comprise harm or potential for harm to the public health and welfare? If so, what is the nature of this harm?

The applicants informed the technical committee members that LMHPs are seeking to increase their scope of practice to include diagnosis and treatment of major mental disorders (MMDs). The proposal would require LMHPs to complete six hours of continuing education pertinent to diagnostics every two years, including ethical aspects associated with the new scope of practice. The applicants stated that LMHPs already make initial assessments of patients and refer those patients with symptoms of MMDs to physicians or psychologists, and that this demonstrates that they already possess the necessary skills to independently diagnose these kinds of mental health problems. The applicants added that currently, LMHPs are required to refer persons with major mental illness to a psychologist or psychiatrist for diagnosis, and then the person comes back to them for treatment with oversight from the doctor. They went on to state that Medicaid coverage extends for four weeks from the first day that the patient sees the LMHP, and stops covering if the person does not see the overseeing practitioner within that timeframe. They informed the committee members that LMHPs cannot see a patient at all until Medicaid approves. Cindy Mayer asked the applicants whether Medicaid works with LMHPs in other states that have the diagnostic piece in their Practice Act. An applicant representative responded that this now occurs in twenty-five states. Another applicant representative commented that the information they have received from their professional groups indicates that Nebraska has the most restrictive scope of practice in the nation for the professions comprising LMHP practice, and that Nebraskans need better access to mental health care than the current restrictions allow. **(Minutes of the Second Meeting, December 10, 2004)**

The applicants stated that the current statutory restrictions in their scope of practice delays access to care for those who need these services, and that the time required to complete the consultation component takes away from the time that could be devoted to the patient. The applicants stated that because of the delays associated with these requirements, some consumers go untreated and suffer the physical and emotional harm associated with lack of needed treatment. The applicants drew the committee's attention to two maps in Appendix C of their proposal, which show the numbers and the distributions of LMHPs and psychologists in Nebraska. They stated that these maps show that LMHPs are an underutilized resource in our state. They added that these maps show that there aren't enough psychologists in the state to effectively supervise the work of all of the LMHPs consistent with delivering services to patients in a timely manner. **(The Applicants' Proposal, Page 15, Question 22)**

The applicants were asked whether oversight of LMHP work could be by a psychologist, a psychiatrist or both. The applicants responded that it can be any of these situations. The applicants were asked whether or not a supervising psychologist could refer a patient with an apparent MMD to an LMHP other than the one that brought the case to their attention in the first place. An applicant representative responded in the affirmative, and added that this situation limits the ability of the LMHP to help patients. **(Minutes of the Second Meeting, December 10, 2004)**

The applicants commented that current restrictions that require consultation with a psychologist for MMD treatment are a waste of time in situations where there is the determination that medications are needed since psychologists cannot order medications. In this scenario the patient would need to be seen by a physician anyway. The applicants were asked whether including a requirement in their statute for consultation in one form or another with other mental

health practitioners might be a good thing for patient care. One applicant representative responded by stating that LMHPs don't like the restrictive aspects of current regulations that require them to consult with other practitioners regardless of the condition of the patient, and which in addition require consultation with a specific practitioner. This representative added that LMHPs should be allowed to use their professional judgement regarding when and to whom a specific referral should be made, and that this would serve the purpose of delivering timely care to patients much better than the current situation. **(Minutes of the Second Meeting, December 10, 2004)**

The applicants believe that the current restrictions fragment the continuum of care for mental health services in our state. Under the current situation some LMHPs choose not to see patients with MMDs due to the time infringements associated with the consultations currently required. The applicants also believe that not allowing LMHPs to independently treat MMDs creates confusion on the part of the public as regards the abilities of the members of this profession. The applicants expressed the opinion that the current restrictions interfere with the consumer's right to choose their provider. **(The Applicants' Proposal, Page 15, Question 22)**

The committee members sought additional clarification as regards the role of LMHPs in the conduct of the treatment plans for patient care under the current situation. Several committee members asked the applicants about the extent to which they are directly involved in treating the symptoms of MMDs. The applicants stated that there is nothing that prevents the LMHP from being involved in the treatment of these symptoms as long as it occurs under the agreed-upon plan and in consultation with the overseeing psychologist or physician. **(Minutes of the Second Meeting, December 10, 2004)**

One applicant representative commented that Nebraska is not attractive to LMHP practitioners from other states because of the restrictiveness of the LMHP practice act in our state. **(Minutes of the Second Meeting, December 10, 2004)**

One opponent testifier stated that the current practice situation enhances public protection by providing additional assurance that diagnosis and treatment of major mental disorders is being done in a manner consistent with highest standards of care. This testifier indicated that required consultation ensures a good continuum of care, and that the resulting liaison among related health professionals will continue to benefit patients in Nebraska. The current consultation requirements are an additional check to ensure that patients are receiving the highest quality of care that is possible. **(Transcript of the Public Hearing, Pages 98, 99)**

2. What restrictions are statutory? What restrictions are in rule and regulation only?

The applicants stated that currently LMHPs are required to refer persons with major mental illnesses to a psychologist or psychiatrist for diagnosis, and then the person comes back to them for treatment with oversight from the doctor. According to one applicant representative, Medicaid coverage extends four weeks from the first day that the patient sees the LMHP, and stops covering if the person does not see the overseeing practitioner within that timeframe. LMHPs cannot see a patient at all until Medicaid approves. Several committee members asked the applicants whether Medicaid works with LMHPs in other states that have the diagnostic piece being proposed in Nebraska in their Practice Acts. An applicant representative responded that this occurs in twenty-five states. **(Minutes of the Second Meeting, December 10, 2004)**

The applicants informed the committee members that under current Medicaid rules LMHPs are required to refer their patients to either a physician or a psychologist regardless of the specific mental health problem of the patient. The committee was told that the overseeing practitioner

in these situations must be signed on with Medicaid. **(Minutes of the Second Meeting, December 10, 2004)**
The applicants were asked where it is written that consultation with the overseeing practitioner has to be once every three months. They responded that this is not in statute but is in Medicaid rules and regulations. The applicants were asked how they would deal with a situation in which a client comes to them with other medical problems. They responded that they would refer the client to a physician, and added that referral in this type of situation is based on their code of ethics. **(Minutes of the Second Meeting, December 10, 2005)**

Several committee members asked the applicants how their proposal could rectify this situation. The applicants responded that once the proposal is passed, applicant group representatives would have a basis from which they could approach Medicaid officials about making changes in Medicaid rules. Dr. Madison commented that it is doubtful that Medicaid would change its policies just because of changes made in a state credentialing statute. He added that Medicaid has always sought to preserve its independence as regards the development of its rules and regulations. **(Minutes of the Second Meeting, December 10, 2004)**

Dr. Spry commented that the Agency should be able to impact Medicaid policies since this program is part of the Agency, and that once the proposal is passed, discussions between the applicants, the Agency, and Medicaid representatives could be initiated pursuant to changing the rules and regulations for LMHPs. **(Minutes of the Second Meeting, December 10, 2004)**

The applicants were asked whether there are any other third party payers that have restrictive policies in this area of care. They responded that "CHAMPUS" also has restrictive policies as regards LMHP practice. **(Minutes of the Second Meeting, December 10, 2004)**

The applicants commented that current restrictions that require consultation with a psychologist for MMD treatment are a waste of time in situations where there is the determination that medications are needed since psychologists cannot order medications. The patient would need to be seen by a physician anyway. The applicants were asked whether including a requirement in their statute for consultation in one form or another with other mental health practitioners might be a good thing for patient care. They responded by stating that LMHPs don't like the restrictive aspects of current regulations that require consultation regardless of the condition of the patient and, in addition, require consultation with a specific practitioner. **(Minutes of the Second Meeting, December 10, 2004)**

The applicants were asked what proportion of their work comes from Medicaid vs. private pay patients. They responded that this is approximately 30% of their work. **(Minutes of the Second Meeting, December 10, 2004)**

3. Are LMHPs qualified to do the proposed scope of practice safely and effectively? Do they have the education and clinical experience necessary?

Successful completion of a masters degree is a prerequisite for becoming licensed as an LMHP. Only those who have met this and any other requirements for licensure would be eligible to do the proposed scope of practice. The applicants provided detailed information about masters level program curricula available in Nebraska in appended documentation to their proposal. **(The Applicants' Proposal, Appendix B and C)**

The committee members asked the applicants to clarify the portion of the proposal that referred to the treatment of organic concomitants of MMDs, and asked the applicants what their preparation would be so as to be able to diagnose these kinds of problems. An applicant

representative responded by stating that this provision refers to the role that the LMHP plays in helping the patient deal with any physical concomitants so as to live as normal a life as possible. It does not refer to the actual treatment of these conditions in a medical sense. Dr. Madison suggested that it might be a good idea to delete the reference to organic aspects from the proposal since it really does not add anything that is not defined previously, and has great potential to create confusion and misunderstanding. **(Minutes of the Second Meeting, December 10, 2004)**

The committee members then began a discussion on education and training issues pertinent to the proposal. Cindy Mayer commented that her review of the information in the proposal relating to education did not generate a lot of information pertinent to the diagnosis of major mental disorders. Cindy Mayer then asked the applicants whether it would be appropriate for new graduates to have the same degree of independence to do major mental disorders as more experienced practitioners. The applicants commented that diagnosis is a component of all LMHP course work, not just one specific course. One of the applicants stated that the proposal would create a requirement for 32 CEs every two years, with six of these specifically focused on diagnostics. **(Minutes of the Second Meeting, December 10, 2004)**

One applicant representative described the information in the proposal related to the programs at UNO and UNK, which are nationally accredited programs. Dr. Madison asked the applicants how many hours of training are needed to complete a degree program. The applicant representative responded that 600 hours are required to complete a degree program, and that 300 of these hours must be in direct patient contact. Additionally, 1500 post-graduate hours are required. Dr. Madison then asked whether they are required to train for a specific number of hours in MMDs. The applicant representative responded that there is no such requirement. **(Minutes of the Second Meeting, December 10, 2004)**

Some committee members commented that as students they were required to log all of the various diagnoses they had done in order to document that they were adequately prepared to perform diagnostics. They asked the applicants whether this is done in LMHP training. They were informed that the progress of LMHP students is measured from one stage to the next throughout programs of study, and if the student is found to be deficient, they must retake those courses successfully or are asked to leave the program. Lisa Runco commented that this approach to documenting competency has become common among many health professions. One applicant representative commented that LMHPs do log specific data about the patients they treat, but not the nature of the diagnosis per patient. Cindy Mayer expressed the concern that each LMHP practitioner needs to be sufficiently trained to do their job competently, and that we should not oversell the ability of a “code of ethics” to somehow overcome any deficiencies in the area of education or training. **(Minutes of the Second Meeting, December 10, 2004)**

Dr. Spry noted that the term “psychotherapy” is a common term used in many of the practice acts included in the new information, and asked the applicants to comment on this term. Mr. Kaminski commented that this term refers to what practitioners call “talk therapy” and is not to be confused with the term “psychoanalysis.” The latter is done only by psychologists and psychiatrists, whereas the former is the principal treatment method used by masters level practitioners. Mr. Kaminski commented that the term psychotherapy is a term that denotes something more than just counseling, and yet is something that does not quite rise to the treatment level denoted by psychoanalysis. **(Minutes of the Fourth Meeting, March 1, 2005)**

Dr. Madison stated that when LMHP was created in the early 1990’s, the concern was to define a role for the newly created credential that would be sufficiently broad to incorporate all of the

various masters level groups that were to be included under the LMHP "umbrella," and yet sufficiently specific to protect the public from harm. He added that the supervision requirement for MMDs was put in the statute to ensure that the public would be protected from those LMHPs who lack the necessary clinical background to diagnose and treat major mental disorders independently. **(Minutes of the Fourth Meeting, March 1, 2005)**

Mr. Kaminski proposed the following changes to the proposal:

1. **Rename the Provisional Mental Health Practitioner as follows:**

   Certified Mental Health Practitioner" (CMHP)
   (a) All supervisory stipulations would remain unchanged
   (b) Graduates from nationally accredited programs would also be denoted by the following titles: (CSW, CMFT or CPC)
   (c) Graduates from non-nationally accredited programs would be given the title of CMHP

2. **CMHP Provisions would be as follows:**

   Those who graduate from a nationally accredited program (such as CACREP, COAMFTE or CSW) would complete, within a minimum of 2 years and a maximum of 5 years, 3000 hours of documented supervised experience. Upon completion, candidates would then be eligible to apply for full and independent licensure as an LPC, LMFT, LCSW and/or LMHP.

   Those who graduate from a program that is not nationally accredited by CACREP, COAMFTE or CSWE would need to practice a minimum of 7 years, and complete 6000 hours of documented supervised experience. During this time, they would need to meet the regulations and legislative guidelines for the current PLMHP designation. They would then be eligible for full licensure as an LMHP or as an LCSW, LPC, or LMFT if they meet the clinical membership guidelines of the respective national association.

3. **Grand-parenting provisions would be as follows:**

   Those who graduate from a nationally accredited program on or before July 1, 2004, and have met the supervision requirements, would be eligible for full licensure on July 1, 2006.

   Those who graduated from non-nationally accredited programs on or before July 1, 1999, and have a minimum of 7 years supervised experience would be eligible for independent practice on July 1, 2006. They would be eligible for full licensing status as an LMHP, or as an LCSW, LPC, or LMFT if they meet the clinical membership guidelines from the respective national association.

4. **Code of ethics provisions would be as follows:**

   All non-nationally accredited program graduates, upon licensure renewal, would need to document which one of the following codes of ethics (ACA, AAMFT, NASW, APA or AMHCA) they intend to adhere to in order to comply with this requirement.

5. **Continuing education provisions would be as follows:**

   The requirement would be that 6 of the 32 hours be specific to diagnostics, taking into account that 2 hours are already designated for ethics training, leaving 30 hours. **(Submitted by the applicant group representative during the fifth meeting of the committee, March 18, 2005)**

Cindy Mayer commented that none of these new proposed ideas addresses the fact that the non-accredited people lack the necessary education and training to provide mental health care in the first place. She asked how can the public be protected from those in the LMHP practice areas that lack the necessary education and training to diagnose and treat MMDs. Mr. Kaminski responded that Nebraska does not have the incidence of severely mentally ill people that is so prevalent on the east or west coasts. **(Minutes of the Fourth Meeting, March 1, 2005)**

Dr. Madison then stated that an additional 4000 hours of supervised clinical experience be required for LMHPs who want to diagnose and treat MMDs independently. Kevin Kaminski responded to this idea by stating that there is no need for an additional 4000 hours of supervised service, and that the grand total of 7000 hours is out of line with what is going on in the rest of the nation. Mr. Kaminski added that neither this idea nor the current practice situation are consistent with the concept of an "even playing field", and that if something isn't done to correct this situation many LMHPs will be leaving Nebraska. Mr. Kaminski then stated that the term "major mental disorder" should be struck from the statute and that no other state in the nation uses this term. **(Minutes of the Fourth Meeting, March 1, 2005)**

Dr. Spry asked Mr. Kaminski whether he feels capable of treating a patient with bipolar disorder. Mr. Kaminski responded in the affirmative and added that to treat the patient he would "follow the book and do what it says." Dr. Spry then asked Mr. Kaminski whether he would consult with other practitioners. Mr. Kaminski responded that he would consult and would do so in a manner consistent with his code of ethics. One applicant spokesperson commented that LMHPs know when talk therapy needs to end and when a referral to another practitioner is necessary. Another applicant spokesperson commented that the real harm stems from overly complex rules and regulations that take up valuable time with needless consultations. **(Minutes of the Fourth Meeting, March 1, 2005)**

Mr. Kaminski commented that because of the timeframes for current consultation requirements and the shortage in the number of available supervising mental health professionals, the current practice situation, for all practical purposes, creates a circumstance wherein the patient is virtually abandoned until the supervising psychologist or psychiatrist can find time to see them. This, according to Mr. Kaminski, is the real source of harm to the public, and the harm that the proposal would eliminate. **(Minutes of the Fourth Meeting, March 1, 2005)**

One applicant testifier informed the committee members that research comparing the outcomes of mental health care delivered by masters level mental health practitioners and doctoral level practitioners has revealed no significant difference in outcomes between the two levels of practitioners. This testifier went on to state that research focused on comparisons of practitioners' abilities to diagnose and treat major mental disorders has produced similar results, namely, that masters level practitioners and doctoral level practitioners do equally well in treating serious mental illnesses**.** Another testifier commented that the evidence that supports this contention lacks scientific validity, and is therefore seriously flawed. **(The Transcript of the Public Hearing, Pages 79 through 81)**

One opponent testifier stated that a review of the educational preparation of the professional groups comprising LMHP indicates that these groups are not prepared to diagnose and treat major mental disorders, and that this aspect of mental health care is not the emphasis of their education or training. This testifier stated that given the great diversity of backgrounds of those regulated under LMHP they would not like to see these practitioners treating people who are suicidal or homicidal. This testifier commented that some LMHPs do not have sufficient background in dealing with mental disease to provide services to severely mentally ill patients.

(The Transcript of the Public Hearing, Pages 117, 119, 123, and 128)

4. **What are the potential impacts of the proposal on the quality of care? Would there be an increased risk of misdiagnosis? Would the proposal increase safety concerns for patients in remote locations where there are very few other mental health practitioners for referral purposes?**

Sheila Minnick asked the applicants how treatment occurs under the present scope of practice, and where LMHP treatment ends and where the treatment of other practitioners begins. The applicants responded that the LMHP carries out the part of the treatment plan that the overseeing psychologist or physician defines for them. Dr. Spry commented that the risk of changing this system is that more timely access to the care in question might result in a misdiagnosis of a patient's condition. One applicant representative responded that it is the current situation with too many "gatekeepers" that puts the patient at risk as regards timely access to quality care. **(Minutes of the Second Meeting, December 10, 2004)**

The applicants stated that initially the legislature created the current restrictions because of concerns regarding the ability of all LMHPs to safely and effectively diagnose and treat MMDs, but that since the passage of the current statute in 1993, national accreditation standards have been enhanced and implemented in graduate programs in Nebraska that teach diagnosis and treatment of these disorders. **(The Applicants Proposal, Page 16, Question 24)**

The applicants provided to the committee members a memorandum from a government affairs official for the American Association for Marriage and Family Therapy pertinent to the issue of possible misdiagnosis of patients who may have a major mental disorder. In his memo this official stated that he had been an ethics case manager for AAMFT for eight years, and in that capacity had investigated alleged violations of the professions code of ethics. This official stated that misdiagnosis by a practitioner would be a violation of the code that requires high standards of competency and integrity. He went on to state that in all of his years as an investigator there was never a finding that an MFT had misdiagnosed a patient's condition. He added that if this aspect of professional practice were a weakness of this profession, then surely evidence to this effect would have shown up in ethics violation cases by now. **(Memorandum from Lincoln M. Stanley, M.A., Government Affairs Manager for AAMFT, February 2, 2005)**

Dr. Spry asked the other committee members to discuss whether they see significant harm to the public in the applicants' proposal, and if so, how such new harm might be handled. He then asked the applicants to discuss the potential for harm from a situation wherein an LMHP misdiagnoses the condition of a patient who has a mental condition stemming from a chemical imbalance, and is in need of a referral to a medical doctor. Mr. Kaminski responded that the consequences in such a circumstance would be no worse than a circumstance in which a psychologist were to misdiagnose this patient's condition since they, like LMHPs, also cannot prescribe medications. **(Minutes of the Fourth Meeting, March 1, 2005)**

Dr. Stull commented on the potential for harm from the proposal by stating that diagnosis in the mental health field is very subjective, and that because of this mental health professionals cannot diagnose as precisely as in other areas of health care. Dr. Stull went on to state that because of the inexact nature of diagnosis in the mental health area, it is easy for a practitioner to get "off track" and get carried away with their particular notion of what might be a patient's condition. He added that a good education plus extensive experience is the best means of avoiding all of the pitfalls associated with this aspect of mental health care. **(Minutes of the Fourth Meeting, March 1, 2005)**

Dr. Madison commented that in the mental health field symptoms can mask deeper problems

that are not always easily recognizable. He stated that because they lack a medical background, LMHPs are likely to misdiagnose conditions that require medical attention. He added that bipolar disorder, psychosis, and anorexia are examples of such conditions. **(Minutes of the Fourth Meeting, March 1, 2005)**

Mr. Kaminski responded to these concerns by stating that no mental health professional is perfect in the area of diagnosis, regardless of whether they are physicians or psychologists or LMHPs. Mr. Kaminski stated that all mental health professionals over the course of their careers will make some incorrect diagnoses. Mr. Kaminski acknowledged that there are some LMHPs who come from unaccredited programs (the so-called "like groups" such as human growth and development and human relations, e.g.) and that many of these practitioners may not have sufficient background in the clinical and therapeutic aspects of care to do the new scope of practice up to the standard of other LMHPs. Dr. Madison commented that Nebraska's situation is unique in this regard because of the "umbrella" nature of the way masters level mental health providers are regulated with so many under-qualified people included under this broad regulatory structure. **(Minutes of the Fourth Meeting, March 1, 2005)**

Lisa Runco commented that no evidence was provided by any of the opponents that even suggested that there is a problem with LMHPs misdiagnosing patients' conditions, and that it seems that the potential for harm from this kind of problem seems to have been overstated. **(Minutes of the Fourth Meeting, March 1, 2005)**

Cindy Mayer commented that none of these new proposed ideas addresses the fact that the non-accredited people lack the necessary education and training to provide mental health care in the first place. She asked how can the public be protected from those in the LMHP practice areas that lack the necessary education and training to diagnose and treat MMDs. Mr. Kaminski responded by posing the question as to whether Nebraska has the incidence of severely mentally ill people that is so prevalent on the east or west coasts. **(Minutes of the Fourth Meeting, March 1, 2005)**

Lisa Runco asked the applicants how they would handle a patient who was diagnosed with schizophrenia. Mr. Kaminski responded that he would assess the patient and consult with a physician for the purpose of creating a treatment plan for the patient. He went on to state that once the plan is put in place, including the prescription of any drugs by the physician, he would then manage the case in order to put the plan into effect. He added that this type of consultation occurs as a natural part of the process of doing mental health care in the real world, and that there is no need to mandate consultation by law when consultation is already a requirement of the code of ethics of each of the professions within LMHP. **(Minutes of the Fourth Meeting, March 1, 2005)**

Dr. Madison commented that the organic aspects of mental health problems are very pervasive and that they are often difficult to assess right away, and are not amenable to "talk therapy" when they are identified. Mr. Kaminski responded that some patients with organic disorders are responsive to the "talk therapy" approach. Dr. Madison commented that patient vulnerability is something the committee members need to keep in mind in all of this, and that it is important for the committee to make recommendations consistent with ensuring that only those with the proper education and training provide the care in question. **(Minutes of the Fourth Meeting, March 1, 2005)**

One applicant testifier informed the committee members that research comparing the outcomes of mental health care delivered by masters level mental health practitioners and doctoral level practitioners has revealed no significant difference in outcomes between the two levels of

practitioners. This testifier went on to state that research focused on comparisons of practitioners' abilities to diagnose and treat major mental disorders has produced similar results, namely, that masters level practitioners and doctoral level practitioners do equally well in treating serious mental illnesses**.** Another testifier commented that the evidence that supports this contention lacks scientific validity, and is therefore seriously flawed. **(The Transcript of the Public Hearing, Pages 79 through 81)**

One opponent testifier stated that a review of the educational preparation of the professional groups comprising LMHP indicates that these groups are not prepared to diagnose and treat major mental disorders, and that this aspect of mental health care is not the emphasis of their education or training. This testifier stated that given the great diversity of backgrounds of those regulated under LMHP they would not like to see these practitioners treating people who are suicidal or homicidal. This testifier commented that some LMHPs do not have sufficient background in dealing with mental disease to provide services to severely mentally ill patients. **(The Transcript of the Public Hearing, Pages 117, 119, 123, and 128)**

5. **Are there viable alternatives to the proposal? Is there any information from other states that might help us identify viable alternatives for Nebraska?**

The committee members asked the applicants to provide evidence that there is harm to the public from the current practice situation, and to look at how Nebraska compares with such neighbor states as Kansas in this regard. **(Minutes of the Second Meeting, December 10, 2004)**

The applicants included in their proposal information that enabled the committee members to compare the scope of LMHP practice in Nebraska with neighboring states. Included in this information were the following items:

- All fifty states and the District of Columbia license social workers. Nebraska is the only state that requires social workers to work under the consultation of either a psychologist or a psychiatrist for the diagnosis of major mental illness.

- Professional counselors are licensed in 48 states and the District of Columbia, and of these, 25 states allow them to independently diagnose and treat MMDs. Regionally, Colorado, Illinois, Iowa, Kansas, Minnesota, Montana, Oklahoma, South Dakota, and Wyoming allow licensed professional counselors to independently diagnosis and treat MMDs.

- Marriage and Family Therapists are licensed in 46 states and the District of Columbia, and Nebraska is the only one of the 46 states that requires consultation for diagnosis and treatment of MMDs. **(The Applicants' Proposal, Page 14, Question 20)**

Several committee members asked the applicants whether Medicaid works with LMHPs in other states that have the diagnostic piece being proposed in Nebraska as part of their practice acts. One applicant representative responded that this occurs in twenty-five states. The applicants commented that the information they have from their professional groups indicates that Nebraska has the most restrictive scope of practice in the nation for the professions comprising LMHP practice, and that Nebraskans need better access to mental health care than the current restrictions allow. **(Minutes of the Second Meeting, December 10, 2004)**

The applicants stated that a partial resolution to the problems identified would be to persuade Medicaid to change regulations that require all consumers, regardless of diagnosis, to be seen by a supervising practitioner. This would not address the statutory restrictions pertinent to

MMDs, but would help with other aspects of access to mental health care. **(The Applicants' Proposal, Page 21, Question 43)**
Dr. Spry asked whether consultations must always be done face-to-face. The applicants responded that this is the case for Medicaid. One applicant representative commented that there are limits to the number of LMHPs that a given psychologist or psychiatrist can supervise, and that there are sometimes situations in which an LMHP cannot find a supervising practitioner. **(Minutes of the Second Meeting, December 10, 2004)**

Dr. Spry asked the other committee members and the interested parties to think about ways in which the current regulatory system for their profession could be made less restrictive. He suggested that they consider whether or not providing for a greater amount of electronic communication between LMHPs and their supervising practitioners might go a long ways toward addressing at least some of the current access to care problems that the profession is facing. **(Minutes of the Second Meeting, December 10, 2004)**

Alaska is one state that has made great strides in using electronic communication to improve inter-professional cooperation and thereby improve access to care.

A representative of the psychologists proposed the following idea regarding how to modify the proposal, and this idea is as follows:

1. Continue current requirements for PLMHPs and LMHPs.
2. Create a second tier for advanced practice requiring the following:
   (a) Certification as CSW, MFT, or CPC in a nationally accredited program.
   (b) An additional 4000 hours of supervised direct service beyond the 3000 hours to become an LMHP.
   (c) At least 4000 of the 7000 hours would have to come from work in a hospital or community mental health center providing direct patient care for persons with MMDs under supervision of qualified practitioners.
   (d) Supervision for the major mental disorders portion of the work to be defined as one hour of individual supervision for each 10 hours of direct client service and that the supervision be based on direct review of audio and or videotaped sessions with patients. Supervision could be done by psychologists, psychiatrists, or advanced practice LMHPs).
   (e) Grand-parenting should be done only for those who fit rigorous criteria such as doctoral degree LMHPs with degrees from nationally accredited programs who can document extensive clinical training and experience in a hospital or community health setting for five years. **(Minutes of the Fourth Meeting, March 1, 2005)**

Information obtained from the states of Utah, Colorado, Minnesota, New York, Ohio, and North Dakota reveals that in these states, whenever supervision of the practices of masters level professional counselors, social workers, and marriage and family therapists is required, their laws allow oversight to be provided not only by psychologists and psychiatrists, but also by advanced practice providers such as psychiatric nurses and clinical nurse specialists. Similarly expanding the range of professions allowed to supervise LMHP practice would be an alternative to the proposal that would hold promise of ensuring quality of care and yet be less restrictive than the current practice situation.

OVERVIEW OF COMMITTEE PROCEEDINGS

The committee members met for the first time on **November 10, 2004** in Lincoln, at the Nebraska State Office Building. The committee members received an orientation regarding their duties and responsibilities under the Credentialing Review Program.

The committee members held their second meeting on **December 10, 2004** in Lincoln, at the Loren Corey Eisley Library. The committee members thoroughly discussed the applicants' proposal and generated questions and issues that they wanted discussed further at the next phase of the review process, which is the public hearing.

The committee members met for their third meeting on **February 4, 2005** in Lincoln, in the Nebraska State Office Building. This meeting was the public hearing on the proposal during which both proponents and opponents were each given one-hour to present their testimony. Individual testifiers were given ten minutes to present their testimony. There was also a rebuttal period after the formal presentations for testifiers to address comments made by other testifiers during the formal presentation period. A public comment period lasting ten days beyond the date of the public hearing was also provided for, during which the committee members could receive additional comments in writing from interested parties.

The committee members met for their fourth meeting on **March 1, 2005** in Lincoln, in the Nebraska State Office Building. The committee members continued their discussion on the proposal.

The committee members met for their fifth meeting on **March 18, 2005** in Lincoln, in the Gold's Building, and at this meeting formulated their recommendations on the proposal by taking action on each of the four criteria of the credentialing review statute.

The committee members met for their sixth meeting on **April 19, 2005** in Lincoln, in the Nebraska State Office Building. The committee members made corrections to the draft report of recommendations, and then approved the corrected version of the report.

The committee members met for a special meeting on **September 23, 2005** in Lincoln, in the Nebraska State Office Building. The committee members reviewed a final version of the proposal that had not yet been developed during their previous meetings, and then took action via the four criteria on this final version of the proposal. By this action the committee members recommended approval of this final version of the proposal. The committee members then adjourned sine die.